**604657 LACERA - Los Angeles County Employees Retirement Association**

# Summary of Benefits Chart for Kaiser Permanente Senior Advantage (HMO) with Part D (7/1/24—6/30/25)

| Plan Out-of-Pocket Maximum | |
|---|---|
| For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount: For any one Member | $1,000 per calendar year |
| **Plan Deductible** | None |
| **Professional Services (Plan Provider office visits)** | **You Pay** |
| Most Primary Care Visits and most Non-Physician Specialist Visits | $5 per visit |
| Most Physician Specialist Visits | $5 per visit |
| Annual Wellness visit and the "Welcome to Medicare" preventive visit | No charge |
| Routine physical exams | No charge |
| Routine eye exams with a Plan Optometrist | $5 per visit |
| Urgent care consultations, evaluations, and treatment | $5 per visit |
| Physical, occupational, and speech therapy | $5 per visit |
| **Telehealth Visits** | **You Pay** |
| Primary Care Visits and Non-Physician Specialist Visits by interactive video | No charge |
| Physician Specialist Visits by interactive video | No charge |
| Primary Care Visits and Non-Physician Specialist Visits by telephone | No charge |
| Physician Specialist Visits by telephone | No charge |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery and certain other outpatient procedures | $5 per procedure |
| Most immunizations (including the vaccine) | No charge |
| Most X-rays and laboratory tests | No charge |
| Manual manipulation of the spine | $5 per visit |
| **Hospital Inpatient Services** | **You Pay** |
| Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs | No charge |
| **Emergency Services** | **You Pay** |
| Emergency department visits | $5 per visit |
| Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share) | |
| **Ambulance and Transportation Services** | **You Pay** |
| Ambulance Services | No charge |
| Other transportation Services when provided by our designated transportation provider as described in this *EOC* | No charge for up to 24 one-way trips (50 miles per trip) per calendar year |

*continued*

| Prescription Drug Coverage | You Pay |
|---|---|
| Most covered outpatient items in accord with our drug formulary guidelines | $7 for up to a 100-day supply |
| **Durable Medical Equipment (DME)** | **You Pay** |
| Covered durable medical equipment for home use | No charge |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric hospitalization | No charge |
| Individual outpatient mental health evaluation and treatment | $5 per visit |
| Group outpatient mental health treatment | $2 per visit |
| **Substance Use Disorder Treatment** | **You Pay** |
| Inpatient detoxification | No charge |
| Individual outpatient substance use disorder evaluation and treatment | $5 per visit |
| Group outpatient substance use disorder treatment | $2 per visit |
| **Home Health Services** | **You Pay** |
| Home health care (part-time, intermittent) | No charge |
| **Other** | **You Pay** |
| Eyeglasses or contact lenses every 24 months | Amount in excess of $150 Allowance |
| Skilled nursing facility care (up to 100 days per benefit period) | No charge |
| External prosthetic and orthotic devices | No charge |
| Meals delivered to your home immediately following discharge from a network hospital or Skilled Nursing Facility | No charge up to three meals per day in a consecutive four-week period, once per calendar year |
| Over-the-Counter (OTC) Health and Wellness products obtained through our OTC catalog | No charge for a quarterly benefit limit of $70 |

This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional information, please refer to the *Summary of Benefits* booklet enclosed; for a complete explanation, refer to the *EOC*.